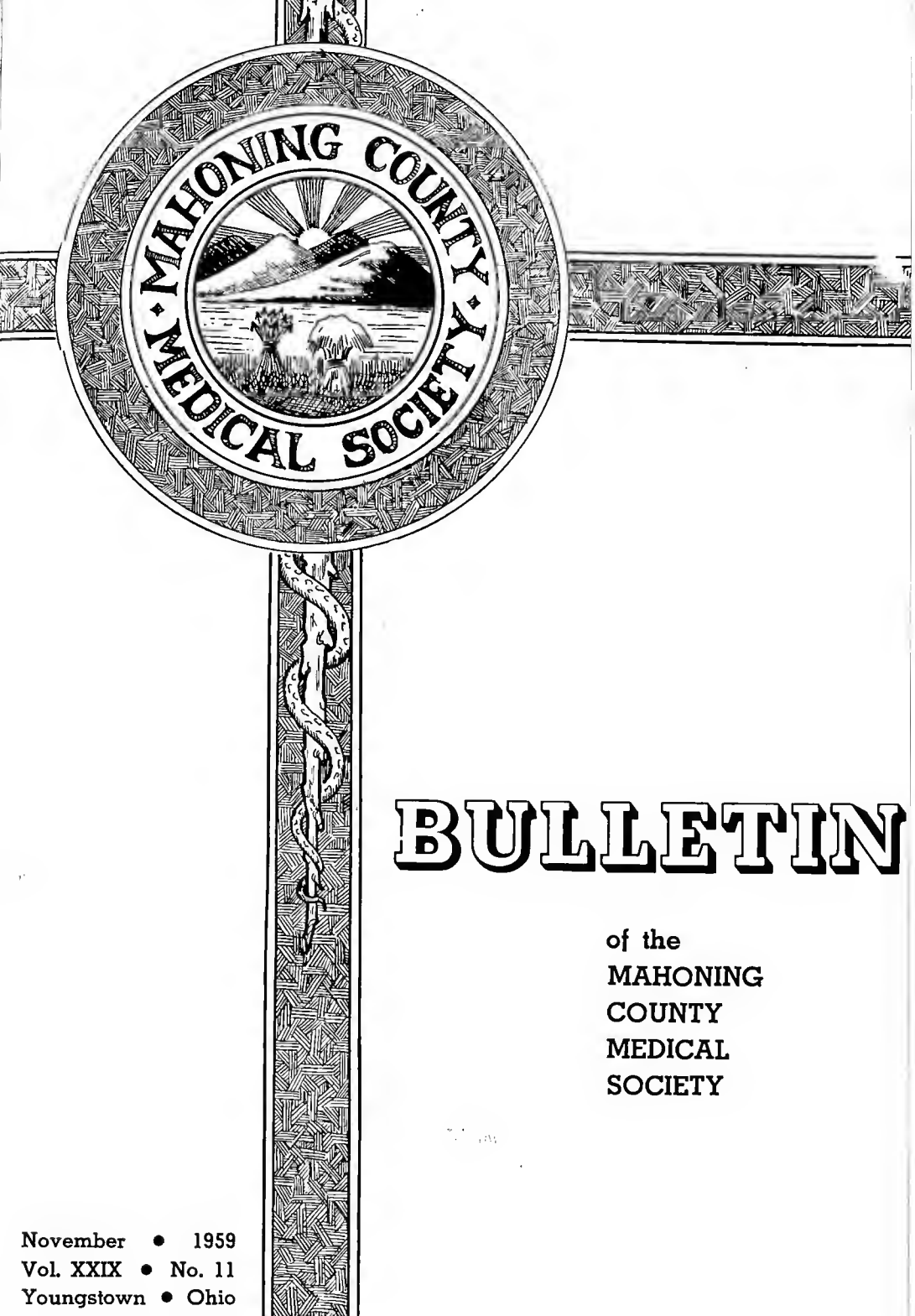

BULLETIN

of the
MAHONING
COUNTY
MEDICAL
SOCIETY

November • 1959
Vol. XXIX • No. 11
Youngstown • Ohio

DIABETES WEEK

November 15 through November 21

Members of the Mahoning County Medical Society will give free tests in this annual campaign to detect diabetes. More than 200 physicians are participating.

●

NOVEMBER MEETING

Tuesday, November 17, Elks Club

DIABETES MEETING—NOMINATION OF OFFICERS

SPEAKER: **Dr. James W. Craig,** Assistant Professor of Medicine, Western Reserve University School of Medicine

SUBJECT: Current Status of the Oral Hypoglycemic Agents in the Therapy of Diabetes Mellitus

6:00 Cocktail Hour
7:00 Dinner — $4.00
8:00 Meeting

Reservations must be made by Saturday, November 14.
Send your reservation and check for $4.00 to:

Mahoning County Medical Society
245 Bel-Park Bldg.
1005 Belmont Ave.
Youngstown 4, Ohio

●

SPECIAL MEETING

Tuesday, November 24, Elks Club

A meeting is being called to discuss Third Party Medicine in this area. Watch the mail for further information.

●

DECEMBER MEETING

Tuesday, December 15, Elks Club

ELECTION OF OFFICERS — BUFFET DINNER

AMA Film Showing — "I Am a Doctor"

OFFICERS AND COUNCIL

OFFICERS

M. W. NEIDUS, Pres. 318 Fifth Avenue
F. G. SCHLECHT, Pres.-Elect 2218 Market Street
A. A. DETESCO, Imm. Past-Pres. 2921 Glenwood Avenue

A. K. PHILLIPS, Secy. 1005 Belmont Avenue
C. W. STERTZBACH, Treas. 3610 Market Street
L. O. GREGG, Editor Dollar Bank Building

Council		Delegates	Alt. Delegates
H. P. McGREGOR	G. E. DeCICCO	P. J. MAHAR (1959)	C. C. WALES
S. W. ONDASH	P. J. MAHAR	H. P. McGREGOR (1960)	J. J. McDONOUGH
M. S. ROSENBLUM	C. E. PICHETTE	G. E. DeCICCO (1961)	R. R. FISHER
H. J. REESE	F. A. RESCH	A. RANDELL (1962)	S. W. ONDASH

Representative to the Associated Hospital Service: J. M. RANZ

Executive Secretary: H. C. REMPES, JR.

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Vol. XXIX—No. 11 **November, 1959**

ADVERTISERS' LIST

Our President Speaks

The other day I felt discouraged for the following reasons: At our monthly meeting of the society we could not submit our revised constitution for lack of a quorum.

Some of the doctors told me that they were being pressured by some patients to keep them on sick benefits during the steel strike. An insurance representative came to see me and told me that they were worried financially, of course, about the increase in sick payments during the steel strike and that the insurance carriers were being made to pay strike benefits under the guise of sickness.

To make matters worse, certain politicians have paid ads telling the citizenry that they are going to take over the practice of medicine.

To add to the dilemma, a fellow called me up and wanted to know what I was doing to get a home for his old mother and wanted to know who was going to take care of her and that he was a war veteran besides, and a non-voting citizen. That fellow felt better after I talked to him but it didn't help his mother.

Suddenly, after a good meal, it dawned on me that troubles are every day problems plaguing mankind and that we have a lot to be thankful for.

Thank God on Thanksgiving Day for our American Ideals and way of life.

M. W. Neidus, M.D.
President

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Volume 29 **November, 1959** **Number 11**

Published for and by the Members of the Mahoning County Medical Society

EDITORIAL

SOCIALIZED MEDICINE

There is an old slogan "United we stand, divided we fall," which is apropos at the present time. As we are being pressured on all sides, by various groups, into a socialized form of medicine, it seems imperative that we take a united stand. I don't mean we should be against everything, but that we should resist all socialistic changes and in its place offer something constructive. Sometimes people forget that free enterprise made this country what it is today and that the world doesn't owe anyone a living.

This applies also to medicine in that, competition plus free choice of physician, has made medical care in this country the best in the world. To change this to so-called third party medical care, with its limitation of free choice of physician, lack of doctor-patient relationship which inevitably occurs would lead to less than the best medical care. There is no question that good medical care is expensive, but we must find an answer other than socialized forms of medicine. Incidently, I don't know of any doctors who turn down a patient if he is without funds.

In order to combat this trend, we must unite, more than ever before, to preserve our private practice of medicine, to assure our patients the best possible care.

L. O. Gregg, M.D., Editor

MEDICAL SOCIETY SPONSORS DIABETES WEEK

Material for the 1959 Diabetes Detection Drive, including Clinitest tablets, posters, and literature has been delivered to the offices of more than 200 physicians by members of the Medical Society Woman's Auxiliary. This diabetes detection campaign is conducted annually by the Mahoning County Medical Society.

Physicians are asked to make diabetes tests free of charge during the week of Nov. 15 through Nov. 21. At the end of the testing period, the Medical Society office will phone for a report of the number of tests made and the number of new diabetes discovered. In addition to the individual doctors' offices, the laboratories of St. Elizabeth Hospital, and Youngstown Hospital, South and North Units, have been designated as testing centers.

The Youngstown Vindicator and all of the television and radio stations in Youngstown have cooperated in publicizing the campaign by means of stories, photos, programs and spot announcements. In addition, members of the Diabetes Committee will speak at service clubs and over the air. Most of the drug stores in the area have cooperated by displaying posters announcing Diabetes Week.

Speaker at the November meeting of the Medical Society will be Dr. James W. Craig, Assistant Professor of Medicine, Western Reserve University School of Medicine. He will speak on "Current Status of the Oral Hypoglycemic Agents in the Therapy of Diabetes Mellitus." The meeting will be at the Elks Club on Tuesday, Nov. 17, at 8:00 p.m., preceded by a dinner at 7:00.

The Diabetes committee for the 1959 drive includes Dr. M. M. Yarmy, chairman Dr. E. R. McNeal, Dr. H. H. Ipp, Dr. M. S. Rosenblum, Dr. W. E. Sovik, Dr. J. B. Birch, and Dr. P. L. Jones. Material for the campaign is furnished by the American Diabetes Association.

NOMINATION OF OFFICERS

Following the Diabetes portion of the November 17 meeting of the Mahoning County Medical Society, there will be nominations for officers for 1960. Nominations made at this meeting will be voted upon at the December meeting.

Some of the officers, council, and delegates will carry over from the current year. In the outline below, those to be nominated are left blank:

OFFICERS: 1960

President:	F. G. Schlecht
Immediate Past President:	M. W. Neidus
President Elect:	_____
Secretary:	A. K. Phillips
Treasurer:	_____

Council: 1960

One year members:	H. P. McGregor	Two year members:	_____
	S. W. Ondash		_____
	M. S. Rosenblum		_____
	H. J. Reese		_____

Delegates: 1960

		Alternates:
1960	H. P. McGregor	_____
1961	G. E. DeCicco	_____
1962	Asher Randell	_____
1963	_____	_____

EXPERIENCE WITH SUPERIOR VENAL CAVAL REPLACEMENT

By Angelo Riberi, M.D.
Department of Surgery, St. Elizabeth Hospital

Superior vena caval occlusion resulting in the well known Superior Vena Cava Syndrome is often a cause for discussion and dissatisfaction. Indeed if the etiology of this syndrome is often obvious, the re-establishment of a satisfactory venous return from the upper part of the body has been for a long time considered unfeasible or at the best unsatisfactory. If one believes the last reports dealing with superior vena caval replacement one is of course left unsatisfied with the results obtained in grafting procedures of veins and of the vena cava in particular.

Neoplasms, aortic aneurysms, non-specific mediastinatis and trauma are the usual etiologic factors in the production of superior vena caval occlusion. If with extensive pulmonary neoplasms replacement has but a very limited indication, it appears obvious that in aneurysms of the ascending aorta, mediastinitis and trauma, which may be today considered benign lesions, grafting assumes a prominent importance.

Unfortunately, as emphasized earlier, much of the clinical and laboratory work on superior vena caval replacement has been discouraging. Caval homografts, and synthetic materials have been extensively tried. Homografts tend to thrombose and Kay demonstrated that only 30% of these grafts remained patent over a certain length of time. Even worse were the results obtained with aortic homografts by Gerbode at Stanford University. All of 25 Homografts used to replace the superior vena cava underwent either thrombosis or fibrosis. No better results were obtained with Homologovs veins and Ivalon tubes. The very complete work of Deterling and Bhonsaly demonstrated the unsuitability of such materials for this purpose.

What are the reasons for failure of superior vena caval grafts? To me they are related to two fundamental reasons: first the type of graft employed would seem to be of primary importance, but second, the real reason for failure remains the slower flow of blood and, most of all, the low intraluminal pressure in the vena cava. This has been amply proven by the fact that almost any type of graft will stay patent for a considerable length of time when the aorta is concerned.

In the aorta a systolic pressure of about 130 mm. Hg. and a diastolic of around 70 mm. Hg. are extremely high figures as compared to caval pressures. If the vessel is kept open by intraluminal pressure, collapse is prevented, endothelization can take its place, and the fibroblastic proliferation invading the graft's wall from the surrounding tissues has but a little chance to constrict and eventually obliterate the lumen of the graft. These considerations are of paramount importance in considering vena caval replacement.

It also would appear obvious that since intraluminal pressure cannot be increased in the vena cava, one should modify the other factor if a suitable result has to be obtained, and this is the graft itself. The larger size of the human vena cava seems to be responsible for the better results obtained with homologous aorta in patients with treatable superior vena caval occlusion. The results however are far from being perfect. Plastics and autogenous veins have also been shown to be poor substitutes.

In search for suitable substitutes for the superior vena cava we have conducted over several years a series of experiments which have been published separately in several surgical journals.

It is the purpose of this article to summarize our findings in the field of superior vena caval replacement and to draw some conclusions.

Autogenous Pericardium

As in any other type of grafts, autogenous materials have the best chances to do the job and to remain viable. Since other materials, including veins, had proven poor, it was felt that maybe a graft made of autogenous pericardium might have some chances of success. This is obviously the only intrathoracic structure which can be sacrificed with a certain degree of impunity and its readily availability to the surgeon seemed to justify its trial.

In dogs, the right chest was opened through a third interspace thoracotomy. The phrenic nerve was dissected free and retracted medially. The pericardium was opened and large rectangular flap obtained. This flap was cleared of all its fat and wrapped around a syringe barrell and made into a tubular graft. The superior vena cava was then dissected free and Potts clamp applied and the vein excised for all its length. The pericardial tube was then grafted and sutured to the vena cava with a careful everting mattress suture of #00000 fine arterial silk. An interesting innovation was the introduction, at that time, of nylon sheets to cover the blades of the Potts clamp to prevent their easy slippage from the clamped vein. Potts clamp work better on artery than veins.

Twelve such grafts were carried out. The results were then studied by cavographic studies first and later by actual dissection of the grafts at sacrifice. Immediate patency was the rule: in fact the grafts once in place looked so much like the resected vena cava that our hopes seem to materialize. However at cavogram all the grafts appeared to be thrombosed and the postmortem confirmed these findings. In all the animals an artificial superior vena caval syndrome had been created.

These findings were then conclusive as to the unsuitability of free autogenous pericardial grafts in the replacement of superior vena cava.

Incidentally, Shumacker had found that, although pericardial grafts worked well for the repair of atrial septal defects in dogs, they were inferior to plastic materials used for the same purpose in the human.

Use of Tubes Made From the Right Atrial Appendage

When failure of pedicled pericardial grafts appeared obvious we began to experiment with a technique that, although new, had been suggested somewhat by the interesting experiments carried out by Gerbode and associates in 1949. These authors had been successful in anastomosing the transected superior vena cava to the tip of the right atrial appendage in 7 out of 10 animals. Although success was not complete this showed definitely the feasibility of such an anastomosis. In our new technique developed after observing carefully the length of the auricular appendage both in humans and experimental animals, a tube was made from the appendage. After the right chest had been opened the canine S.V.C. was dissected free for all its length but was left unclamped. The pericardium was opened widely and two Potts coarctation clamps were applied side by side to the wall of the right atrim just above the right coronary artery and along the root of the aorta. The atrial wall was incised between these two clamps and thus a moderately long pedicle tube was obtained from the right atrium and auricular appendage. The divided segments of atrial wall were then sutured by means of a running suture of #4-0 arterial silk. A tube measuring about 4 cm. in length was thus obtained. The superior vena cava was then clamped as high up as possible, ligated at its cardiac end together with the azygos, and excised. An end to end anastomosis was then performed between the newly created tubular graft and the stump of the vein. An everting mattress suture of #5-0 arterial silk was used. This operation was carried out in

24 animals. All survived the procedure and the graft remained patent well up to and beyond 6 months in all but one of the dogs in which a technical error was the cause of failure. All cardiac arrhythmias were prevented by procaine block of the sinoauricular node. This indeed seemed to be the perfect type of graft for superior vena caval replacement although it was at that time anticipated that this technique might not be used in cases where the vena cava is obliterated high up at the junction with the innominate. Our results however seem to offer at least a technique of definite value in a certain number of cases.

Use of Autogenous Aorta

Having gone this far and knowing about the poor results obtained experimentally with autogenous veins and homologous arterial grafts, it was decided to use, as a graft, fresh autogenous aorta. This is a difficult undertaking because of the necessity to obtain a large aortic graft, the needs of replacing the aortic gap with some other type of graft, and furthermore the absolute necessity to use the aortic graft while fresh. The following procedure was then developed. Under moderate hypothermia, a left thoracotomy was carried out, the thoracic aorta dissected free just below the left subclavian artery and after ligation of the intercostal branches, a segment of aorta measuring some 6-8 cm. in length was excised and preserved in saline solution. Alcohol preserved aortic homografts were then used to bridge the defect in the descending aorta. This was carried out in the usual fashion. The left chest was then closed in layers. The animal was then turned and a right thoracotomy carried out as described previously. The superior vena cava dissected free and, after application of Potts clamps which blades were covered by nylon sheets, it was excised for a length of 4 to 6 cms. The axygos vein was ligated at the end of the anastomosis. The animals were then returned to their cage when fully reacting. The results with this type of graft were uniformly successful. Although there existed a definite discrepancy between the autogenous aortic graft and the vena cava (the aorta being the smaller of the two), the patency was uniformly obtained by cavogram, autopsy or both from one day to one year after the replacement.

It would appear that auotgenous aorta could be the ideal substitute for cases where the superior vena cava is obliterated in all its length. It was and it is realized that this may be a formidable procedure to use in man, however with the routine use of transverse thoracotomy and with the good results obtained clinically with different types of grafts in the aorta, this procedure should not be discarded a priori just because of its difficulty, particularly when a benign caval obstruction is present.

Use of Bovine Aorta Preserved in Alcohol

Having been at times surprised by the prefect function of some heterologous grafts placed in the canine aorta we felt that this type of graft should at least be given a trial as a venous substitute. Having previously shown the value of alcohol in preserving homologous vessels, we stored segments of bovine aorta in this medium and we used them to replace the superior vena cava in a number of dogs. These grafts were preserved in 70% alcohol for a length of 7-8 months. They were reconstituted prior to surgery in a solution of normal saline containing penicillin and streptomycin. Although a poor result was somewhat anticipated we were amazed to observe that in about 75% of the animals investigated up to 18 months postoperatively, the graft had remained patent.

Although these implants were not uniformly satisfactory, their successful use in 85 per cent of our animals is certainly significant. It is felt that more

work should be done along these lines to ascertain the value of these grafts. Their easy availability, their size comparable to the human vena cava would be a tremendous asset in this field.

Value of Patch Graft

Since obviously all the grafts employed have some pitfalls, it was recently felt that on occasions, as in stab wounds or bullet wounds of the vena cava when only a portion of the venous wall is damaged, may be a reconstruction of the vessel could be possible without the use of a graft. This situation is easily reproduced in the experimental laboratory, by excising a sizable portion of the superior vena caval wall and by replacing it with an autogenous, homologous or plastic material. In experiments which are under way, fine nylon fabric has been used for this purpose and in the first angiographic studies carried out in these animals no narrowing or thrombosis have developed at the area of the graft.

Summary

Superior vena cava syndrome presents a great challenge. The need for its surgical correction has again been stressed. The value and pitfalls of the different type of grafts used for this purpose have been briefly discussed. Several personal techniques have been reviewed and the results obtained analyzed.

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DR. GUSTAFSON HONORED

Dr. C. A. Gustafson, past-councilor of the Sixth District of the Ohio State Medical Association, was honored with a plaque in a surprise presentation at the Postgraduate Assembly held in Warren last month.

During the banquet, Dr. Gustafson was called forward to receive the citation, which read:

Award of Excellence
presented to
C. A. Gustafson, M.D.
for a demonstration of concern to humanity
and his fellow practitioners in his
unselfish and faithful service as
Councilor Sixth District
Ohio State Medical Association
1953 — 1959

The presentation was made by Dr. R. E. Tschantz, who succeeded Dr. Gustafson as Sixth District Councilor.

PREINVASIVE CERVICAL CANCER AND SCHILLER TEST

One of the greatest rewards in the use of routine exfoliative cytology is the discovery of an asymptomatic and unsuspected cancer of the cervix. In many cases of truly early cancers, the lesion may be small, superficial and localized. That no characteristic signs and symptoms are complained of by the patients and no special tissue changes are observed on physical examination is quite understandable. It may be said that the diagnosis of a preinvasive cancer is a microscopic rather than a clinical endeavor. Once treated, the prognosis for the patient is excellent.

However, since a cytodiagnosis must be confirmed by a histodiagnosis before definitive treatment is undertaken, each case should be further studied with tissue biopsies. As the lesion may be of only microscopic dimensions, the chosen biopsy may not contain any abnormal tissues. In recent years this vexing situation has been occurring with greater frequency. Indeed, the early detection of cancer by means of exfoliative cytology has created more problems for the pathologists and for the clinicians as well.

Therefore any test that may point out the possible location within which may lie the diseased tissue is helpful. Schiller Test is one of these useful procedures. For many years, this misconstrued test was considered disappointing and its use largely abandoned. However, a reappraisal shows its proper use and significance. To be sure, the Schiller Test is not a cancer detection test. It is based on the color reaction between iodine and glycogen and merely differentiates the tissue which contains glycogen from that which does not.

Normally, the squamous epithelium of the exocervix and the vagina is rich in glycogen so that when iodine solution is applied the epithelium takes on a homogeneously deep mahogany or brown color. This reaction is called *Schiller Negative*. Any condition, benign or malignant, which causes a loss of glycogen from the squamous epithelium is not stained and is said to be *Schiller Positive*. Since the columnar epithelium of the cervix does not normally contain glycogen it is also unstained or Schiller positive. It is obvious that the terminology is confusing and simplified terms such as *iodine positive* and *iodine negative* have recently been adopted. With this understanding, it is clear that common benign lesions such as cervical erosion (partial loss of squamous epithelium of exocervix and cervical eversion, rolling out of columnar epithelium of endocervix) may be iodine negative, or Schiller positive. In addition, other benign changes such as leukoplakia, metaplasia, and anaplasia as well as preinvasive and invasive cancers can all be iodine negative or Schiller positive. However, it is in the clinically unsuspected early cancers where the lesions are not visible microscopically that the Schiller iodine test can be most helpful in delineating areas from where biopsies may be taken for diagnosis.

The test is simple and consists in painting the cervix thoroughly with Grams iodine (1 part of iodine, 2 parts of potassium iodide and 3 parts of water). Excessive mucous secretion from the cervix should first be gently removed. Care should be taken to avoid traumatizing the mucous membrane since this decreases the staining response. The iodine solution is applied liberally over the cervix. After a minute or two, allowing the stain to be absorbed, the excess solution is gently sponged off and the surface of the epithelium is examined. The unstained area stands out in sharp contrast with the stained and biopsies taken within the unstained area may contain abnormal tissue. In addition, since normal columnar epithelium is iodine

negative and since many cancers begin near the squamocolumnar junction of the cervical mucosa, biopsies taken along the demarcation between iodine positive and negative areas may include both types of epithelium on either side of the transition therefore increasing the possibility of a proper diagnosis in certain cases.

In summary, the chief value of the Schiller Test is in pointing out areas for biopsy, especially in cervices where no physical signs are visible. The iodine negative areas may indicate either the diseased squamous epithelium (benign or malignant) which has lost its glycogen, or simply the normal columnar epithelium adjacent to the squamocolumnar junction. Since many malignant tumors begin in this area, biopsies taken along the squamocolumnar junction will increase the efficiency of tissue diagnosis, especially in cases of unsuspected early cervical cancer discovered by cytodiagnosis.

Winifred Liu Mutschmann, M.D.

MAHONING COUNTY IN CANCER STUDY

As reported in the July 11, 1959 issue of the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION, the American Cancer Society is undertaking a large-scale study of cancer in relation to various environmental factors. The plan is to enroll about 500,000 families, nationwide, of which about 1620 will be enrolled in Mahoning County between November 1 and 15. Volunteer workers of the Society will be used to enroll families in which there is at least one person over the age of 45 and then request every member who is over the age of 30 to fill out a questionnaire. In order to keep the information confidential, each subject will put his fill-out questionnaire in an envelope and seal it before returning it to the volunteer for transmittal to the research center. The volunteers will not interview the subjects and will not see the completed questionnaires.

The subjects will be followed annually for six years to determine which of them die in this interval. Causes of death will be ascertained from death certificates. When cancer is mentioned on a death certificate, the physician who reported it will be requested to supply additional medical information (e.g., histologic type, stage of disease at time of diagnosis, etc.).

The major purpose of the study is to ascertain the association, if any, between various environmental factors (such as occupational exposures, habits, diet, factors related to the breast and female organs, etc.) and the later occurrence of cancer. It is hoped that this will yield clues as to a number of possible causes of cancer.

In addition, it is hoped that the study will provide information of value in relation to lay education. The subjects are asked detailed questions about "present physical complaints" and the answers will be analyzed in relation to cases of cancer diagnosed in the subsequent several months. In order to avoid biasing the subjects, questions are asked about physical complaints which are probably not related to cancer as well as about complaints which may be symptomatic of cancer. Assuming, as is probable, that positive answers to certain of these questions are highly related to the presence of cancer, the data should be of value in persuading people with such complaints to see their doctor immediately. The aim, of course, is to reduce the factor of "patient delay" in the diagnosis of cancer.

—R. L. Jenkins, M.D.

FROM THE BULLETIN

Twenty Years Ago—November 1939

President Skipp gave thanks for the observance of the Code of Ethics which had produced such a fine standard of conduct among our members. He wrote "Ethics may be of two kinds, those we practice and those we preach. Our Society has narrowed this distinction to the vanishing point. Rights of brother practitioners are recognized and respected. Innuendoes by action or word of mouth do not lay ground work for malpractice suits. Fee splitting is unknown in the relationship of family doctor and specialist."

Twenty years later let us take care to keep it that way.

In 1875 Dr. Wm. Pepper of the University of Pennsylvania reported the use of blood transfusion in the treatment of pernicious anemia. This is the first recorded transfusion in America. In Rome in 1615 Libavus described how to let the blood flow from the arteries of a healthy youth to someone exhausted in strength "through silver tubes" guided by a master of the art to "drive away all languor." This before Harvey's discovery of the circulation in 1628, which shows that in the seventeenth century transfusion was being tried. Transfusions of sheep's blood produced disastrous results and often that of man to man until Moss published his monumental work on blood groupings in 1910. John Braxton Hicks of version fame used transfusions for obstetrical hemorrhage employing sodium phosphate as an anti-coagulant. Editor Patrick contributed this interesting historical article on transfusions.

In our own hospitals forty years ago, direct transfusions were given with the Unger of Scannell syringes. It was an operating room procedure with donor and recipient lying side by side on carts with the operator between them. He used a 3-way syringe lubricated with sterile petrolatum. One tube went to the donor, one to a bowl of normal saline and one to the recipient. A needle was inserted into the donor's vein and the blood flowed into the syringe. Then a needle was inserted into the recipient's vein, the 3-way valve on the syringe was turned and the blood was forced into the recipient's vein. The valve was then turned half-way and the syringe was filled with saline which was injected into the recipient. The valve was turned again towards the donor and the syringe filled with blood. A nurse stood by to count the number of syringes full of blood the recipient received. Sometimes it went well and after 15 or 20 syringes full (20 cc. each) the operation was done. No anti-coagulant was used.

Often it did not go well. The recipient's veins were collapsed and by the time the needle was properly in the vein, coagulation had occurred and the syringe was stuck. Syringes were changed frequently because they became clogged even with the use of saline which was intended to prevent that difficulty. It was most terrifying when the recipient suddenly complained of pain in the chest and dyspnea which called for immediate cessation of the operation and supportive measures. Blood typing was done before hand but there was no cross matching, Rh factors were unknown and there were frequent reactions. The writer can recall one case where the donor had been on a binge the night before and the recipient suffered a terrific hangover.

If you want to hear about transfusions in those days just ask Paul Harvey. Even today there are factors in blood we do not know about and twenty years later our successors will laugh about our ignorance.

Ten Years Ago—November 1949

President McCann urged everyone to support the Community Chest. That is a good idea today.

There was a big meeting of the Sixth District Post-Graduate Day that month at the Pick-Ohio Hotel, with four speakers from the Lahey Clinic. They lectured about ulcerated colitis, bronchiectasis and cancer of the lung. The meeting was well attended but compare it with last month in Warren where there were twenty outstanding speakers in the new Packard Auditorium and the place was jammed.

We have gone a long way in the past ten years in post-graduate education. Nowadays a doctor has only himself to blame if he does not keep up with modern medicine. He has so much literature thrown at him, so many hospital programs and so many attractive conventions to attend that it is difficult to select the best.

As a minimum it may be suggested that a doctor should attend his County Medical Society Meetings, the AMA convention, one meeting of his specialty group and all the hospital meetings.

Health Commissioner Tims was promoting a rat control program. When they closed the city dump all the rats moved into the adjacent neighborhood.

J. L. Fisher, M.D.

SOCIETY FAVORS SOCIAL SECURITY

On September 25 a post card ballot was mailed to all active members of the Mahoning County Medical Society, asking them to vote on whether or not the Society should present a resolution to the House of Delegates of the Ohio State Medical Association favoring Social Security for physicians.

Result of the ballot:

Sent out	291	
Returned	208	71.4%
YES	176	84.6%
NO	32	15.4%

GLAUCOMA IDENTIFICATION CARD

The A.M.A. has given official recognition to the Glaucoma Identification Card of the National Foundation for Eye Care, which has been produced and distributed with the valued cooperation of Abbott Laboratories, Inc. The House of Delegates, meeting in Atlantic City on June 11, 1959, adopted a resolution declaring that:

"WHEREAS, glaucoma is a leading cause of irreversible blindness in adults in the United States, and

"WHEREAS, The National Medical Foundation for Eye Care has introduced a Glaucoma Identification Card which will identify glaucoma patients to all attending physicians in any circumstance, especially in emergency, and thus facilitate the continuity of medical care which is essential in the management of the disease and the prevention of blindness from this cause, therefore

"BE IT RESOLVED, that the attention of the members of the medical profession be directed to the Glaucoma Identification Card which will make immediately available to all attending physicians information concerning the patient's use of and requirement for miotics and other medications."

PROCEEDINGS OF COUNCIL
Oct. 12, 1959

The regular monthly meeting of the Council of the Mahoning County Medical Society was held on Monday, October 12, 1959 at the office of Dr. M. W. Neidus, 318 Fifth Ave., Youngstown, Ohio.

The following physicians were present: M. W. Neidus, President, presiding, C. E. Pichette, F. A. Resch, F. G. Schlecht, H. P. McGregor, J. J. McDonough, H. J. Reese, G. E. DeCicco, S. W. Ondash, P. J. Mahar, A. K. Phillips, C. C. Wales, also Jack Schreiber.

Meeting was called to order at 9:25 p.m. The minutes of the previous meeting were read and approved.

Dr. Neidus read a letter from Sid Davis. It was suggested that the letter be printed in the *Bulletin*.

Dr. McDonough reported on the results of a recent postcard ballot to determine whether the Mahoning County Medical Society should submit a resolution to the Ohio State Medical Association favoring Social Security participation by physicians. The ballot showed 84.6% of the Society was in favor of submitting the resolution.

Dr. Schreiber announced that the management of WKBN requested permission from the Medical Society allowing them to acquire a suitable sponsor for the program "Consultation." Following discussion, the motion was made, seconded, and duly passed that WKBN be permitted to secure a sponsor with the reservation that the Medical Society might accept or reject the sponsor in accord with the ethical concept of the medical profession.

The executive secretary was asked to read a political ad which announced the future establishment of a medical and dental clinic in Youngstown by a non-medical group. This was followed by discussion.

The following applications were presented by the Censors and read by the secretary.

Active Membership

Ernest Eugene Alvin, 220 Lincoln Ave., Youngstown, Ohio
Ching Chi Chen, 1009 Belmont Ave., Youngstown, Ohio
Henry S. Ellison, 611 Belmont Ave., Youngstown, Ohio
Curtis J. Fisher, 3025 Market St., Youngstown, Ohio
Harry W. Haverland, Youngstown Hospital, North Side
Allen Howard Holt, 3031 Market St., Youngstown, Ohio
John Arthur Hyland, 2722 Mahoning Ave., Youngstown, Ohio
Winifred Liu Mutschmann, Youngstown Hospital, North Side
Joseph W. Tandatnick, St. Elizabeth Hospital
Samuel F. Petraglia, 215 Main St., Poland, Ohio
Julius Nemeth, 128 W. LaClede Ave., Youngstown, Ohio

Associate Membership

John Thomas Martin, 207 Mahoning Bank Bldg., Youngstown, Ohio
Nicholas B. Salistean, 3718 Market St., Youngstown, Ohio

Jr. Active Membership

James Edward Might, 21 Wickliffe Circle, Youngstown, Ohio
Charles Howard Norchi, Jr., 402 Oak Hill, Youngstown, Ohio
Richard Roland, 5532 Mahoning Ave., Youngstown, Ohio
Joseph H. Sloss, 604 Home Savings and Loan Bldg., Youngstown, Ohio
Sanford R. Weiss, Youngstown Hospital, North Side

Non-Resident Membership

S. E. Tochtenhagen, 512 North State St., Girard, Ohio

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Intern-Resident Membership

Harold John Hassel, Youngstown Hospital
John Joseph McCague, Jr., St. Elizabeth Hospital
Donald James McSurdy, Youngstown Hospital
John Charles Melnick, Youngstown Hospital
Nejdat Mulla, St. Elizabeth Hospital
Daniel T. Pompey, St. Elizabeth Hospital
Max Jay Spencer, St. Elizabeth Hospital

The above applicants will become members of the Society unless objection is filed in writing with the secretary within fifteen days.

Bills were read. A motion was made, seconded, and duly passed to pay each one. A list of bills is attached to the minutes.

Meeting was adjourned.

A. K. Phillips, Secretary

TWO NAMED HONORARY MEMBERS

Two active members of the Mahoning County Medical Society were elected to Honorary Membership at the October 13 meeting of the Society. They are: Dr. Donald M. Rothrock, and Dr. Michael J. Sunday.

JUVENILE COMMITTEE APPOINTMENT

Dr. Sidney L. Davidow has been appointed to represent the Mahoning County Medical Society on the Citizen's Committee on Juvenile Delinquent Services in Mahoning County.

The Citizen's Committee is sponsored by the Health and Welfare Council of the Community Chest and by the League of Women Voters. It has, as one of its primary objectives, facilitation of an impartial study of Juvenile Court, Detention Home and Police Juvenile Services for children in trouble.

HAPPY BIRTHDAY!

Nov. 17
J. J. Turner
Nov. 18
H. N. Bennett
F. R. D'Amato
Nov. 19
M. I. Berkson
J. G. Costantini
Nov. 20
E. C. Baker
Nov. 21
C. A. Whitten
Nov. 22
G. D. Fry
A. C. Marinelli
Nov. 23
B. M. Schneider
Nov. 24
C. S. Lowendorf
R. R. Morrall
Nov. 25
P. J. McOwen
V. Holonko
Nov. 26
S. V. Squicquero
Nov. 27
R. V. Bruchs
Nov. 28
W. L. Agey
C. H. Weidermier
Nov. 30
S. E. Tochtenhagen
Dec. 1
D. R. Bernat
C. Scofield
Dec. 2
C. A. McReynolds
Dec. 3
C. F. Wagner
Dec. 4
H. J. W. Marcella
Dec. 10
H. L. Shorr
B. M. Bowman
Dec. 13
D. Nesbit
E. A. Shorten
Dec. 14
D. M. Rothrock
Dec. 15
F. G. Kravec

INSURANCE HISTORY

The history of insurance takes us back to experiments and plans which people have carried on through the years in the sharing of risks. Some were highly organized—while some were merely the practical solution to a troublesome problem. All plans to share the risks which are a part of life itself.

The Bible story of Joseph is the first example of insurance. He interpreted the dream of Pharaoh about seven fat cows being eaten by seven lean cows as seven years of plenty followed by seven years of famine. He recommended the storing of great reserves of food during the years of plenty to take care of the people during the hungry years. This storing of a surplus is insurance—any surplus that is not being currently used is insurance. It is being saved for future use. Joseph spread the risk in years of plenty for an uncertain future.

About 900 B.C. we find the Rhodean Sea Law. The Island of Rhodes was shipping to the then known world and they were suffering losses at sea. The ships caught in a storm would lighten their load by throwing over-board some of their cargo. To share this loss, their law stated that all people concerned were to share in the total value of the shipment being made so that the risk was shared. This law was so popular that Romans copied it into their Justinian Code some fifteen hundred years later.

The Romans had many insurance principles in use. Roman soldiers were paid money to celebrate victories. Part of this money was deposited, to be paid to them when they left the Army or was for payment to their relatives upon the soldier's death.

The Romans had burial associations. Their worship of gods and goddesses of mythology included costly burial ceremonies. The burial association provided this money. Members of all ages paid the same fee and no member paid for longer than fifty years. No money was paid if a member did not make his regular payments or if a member committed suicide. The risk was shared again in this type of association.

Guilds carried this sharing the risk a little further and offered assistance to those members in poverty, those who lost ships or crops or goods by fire and burial expenses for those who died. The principle of risk sharing was growing so that one man did not have to suffer the loss or hardship by himself.

The Craft Guilds when men of the same occupation banded together offered the same type insurance but they also included orphans and widows. Through this guild a member was protected during life and his family was cared for after his death. Due to the power of the Guild they were suppressed but friendly societies took over the insurance phase of the Craft Guilds. In 1819 the British parliament described these societies and their idea of Mutual Insurance by sharing the risk.

The earliest recorded life policy on a William Gibbons was written in 1853 and even closed with a prayer phrase, "God send the said William Gibbons health and long life." This didn't help, he died a year later and the policy was paid.

Sir Walter Raleigh supported the first marine insurance statute that was placed on the books in 1601. Daniel Defoe who wrote Robinson Crusoe also commented on early insurance.

Early societies limited their membership and had one flat rate. The only requirement at that time was that the insured be in good health and in a non-hazardous occupation.

Around 1700 a society was formed that had the first perpetual insurance. Previous to this all policies were for a term basis only. This society also had the first character and physical examinations.

Marine insurance continued during this time to grow at the fastest rate. Due to lack of communications in those days, most news was exchanged at coffee houses. Lloyds Coffee House was the most famous of these gathering places for transacting insurance business since men of money must meet to guarantee the insurer. This coffee house developed into Lloyd's of London.

In 1762 the first insurance using graded premiums according to age was started. The company was not to make profit and after fifteen years a return of surplus was made and this was the first dividend.

Actuarial records started early. In Rome a famous lawyer Ulpianus formulated a table showing annuity values since law at that time decreed that an income left to a beneficiary should be calculated. He recognized the variation in life expectancy according to age, i.e., 40 or 45 had 19 years income value. 60 or over had 5 years income value. Each age had a factor of income.

Various other men established tables. Edmund Halley the famous astronomer and discover of the Comet bearing his name, worked up the first published mortality table. Blaise Pascal a Frenchman was the first to work up the law of probabilities which can give predictable results when a large number of cases is used. This was further expanded by Edmund Hoyle the man responsible for the expression "according to Hoyle." This law of probabilities along with mortality tables made it possible to have your first scientific approach to the determination of an insurance premium.

Sharing the risk has come a long way and all men who had a hand in it are to be commended. Picture this—old men whose earnings were cut off, whose savings were gone but still had their life insurance would be placed on the auction block. In early days a contract had no surrender values but it did have a speculative value. Men would bid on these contracts at a fraction of their value, secure them, pay the premiums and collect at the insured's death. Insurance has come a long way and is a most sound financial institution that makes it possible for you to share the risk.

—J. R. Workman

LETTER

Dear Dr. Neidus:

I am just now able to write thanking you and the members of the society for the resolution in my behalf.

I was away from Washington for 14 days touring the country with Khrushchev and was surprised and pleased when I returned and opened your letter.

The kindness of the words in the resolution was just another example of kindnesses shown to me while working with the organization of medical people in Mahoning County.

I have carried many memories with me from my hometown, and your consideration, and the consideration of all of the doctors will remain among the warmest.

Thank you and all of the members of the society and please convey to them my appreciation for their extra-thoughtfulness.

Washington being a convention city, I will expect some Youngstown delegations in attendance. I would welcome a call from any of my friends if they find the time.

Sincerely yours,

Sid Davis

MEDICAL GLEANINGS

SUBTHRESHOLD DIABETES by Julius Pomeranze, M.D. New York, N. Y. Annals of Internal Medicine Vol. 51, No. 2 August, 1959

DISCUSSION

Diabetes mellitus may be acquired or inherited and, in the latter instance, is present from both for years, and not just after hyperglycemia and glycosuria are found. Acquired diabetes, in the sense that no heriditary weakness exists, is probably rare and is associated with total or subtotal pancreatic destruction or surgical ablation. In the diabetic patient, degenerative diseases are present, at a younger age, and are similar to those which eventually occur in all people if they live long enough. Embryopathy and acceleration of degeneration are integral parts of the hereditary syndrome, and do not seem to depend upon abnormalities in carbohydrate metabloism for their presence. Never the less, poor chemical control does appear to influence these conditions. A diabetic patient inherits the capacity for failure of carbohydrate metabolism and for increased degenerative changes. The primary presence of subclinical degenerative changes associated with impairment of functional capacity emphasizes the need for a broader awareness of the distribution and frequency of asymptomatic complications. It is during this period that the insidious development of complications, is initiated and projected. It is also during this period that recognition and the institution of dietary habits will most benefit the patient.

The glucose tolerance test is not sufficiently sensitive, since removal of stressful states and of excess caloric intake may result in a "normal" response. The cortisone-modified glucose tolerance test can be used to develop the diagnosis further. However, the awareness of latent diabetes is the critical diagnostic element.

From birth until old age, the physical, emotional and intellectual progress of the individual is mediated to a large extent by the food he is taught to eat. Eating habits superimposed on biologic weakness and environmental stresses can determine the length of life, as well as the gratifications derived from it. The therapy of a chronic disorder such as diabetes mellitus can be eminently satisfactory when recognition is achieved early and effective nutritional therapy instituted and maintained throughout life.

The response to early treatment will depend to some extend upon the the remaining reserve insulin-producing capacity of the beta cells. But in most subjects the response to proper therapy will be good. The balanced eucaloric diet which maintains normal weight and good nutrition in diabetes mellitus is the sine qua non, when instituted before repeated and prolonged stressful overalimentation encroaches upon the reserve metabolic strength.

OPTIC NEURITIS AND UNCONTROLLED DIABETES MELLITUS IN 14 PATIENTS

By Penn G. Skillern and George Lockhart, III
Annals of Internal Medicine Vol. 51, No. 3, September 1959

SUMMARY

Fourteen Patients with optic neuritis or optic atrophy and uncontrolled diabetes mellitus were selected for study; patients with any condition known to cause optic neuritis other than diabetes mellitus were excluded. Three patients in the series used tobacco; two patients drank alcohol. The ages of the patients ranged from 40 to 69 years.

All of the patients had noted loss of vision. Examination disclosed that 12 patients had undiagnosed moderate or severe diabetes mellitus. Blood

sugar values on admission were more than 200 mg. per 100 ml. in all patients except one; in seven they were more than 300 mg. per 100 ml. Thirteen patients had three or four glycosuria. Nine patients had symptoms of diabetes mellitus. Three patients had peripheral diabetic neuritis. Diabetic acidosis was absent in all of the patients.

The onset of the visual loss was gradual in 16 eyes and rapid in six eyes. The visual loss, ranging from moderate to severe, was bilateral in eight patients and unilateral in six patients. Papillitis was observed in seven eyes and optic atrophy in 13 eyes. Seven eyes had central scotomata, and 11 had peripheral contraction of the visual fields. Control of the diabetes mellitus arrested the visual loss in all but one of the patients who were followed. However, only one patient showed significant improvement in vision after the diabetes mellitus was controlled.

On the basis of data gathered from several previously published case reports and the 14 patients in this series, its is suggested that visual loss may be caused by the toxic effect of uncontrolled diabetes mellitus on the optic nerves in susceptible patients.

R. L. Jenkins, M.D.

WOMAN'S AUXILIARY NEWS

The Sixth District Councilor meeting was held October 21st in Warren, Ohio. The Women's activities for the day consisted of a coffee in the morning following registration and a punch hour preceding a luncheon for one hundred forty-five at the Christ Episcopal Church. A skit and style show followed with Mrs. C. A. Columbi, state president, as guest of honor.

During the afternoon and evening a cocktail party was held at Venaro's Restaurant followed by a dinner for seven hundred at the Packard Music Hall.

Those representing the Woman's Auxiliary to the Mahoning County Medical Society were as follows:

Mrs. W. H. Evans	Mrs. Edward Rizk	Mrs. Barclay Brandmiller
Mrs. A. E. Rappoport	Mrs. Dean Stillson	Mrs. A. William Geordan
Mrs. Arnoldus Goudsmit	Mrs. Robert Fisher	Mrs. James Gordon
Mrs. George Cook	Mrs. Paul Mahar	Mrs. J. R. LaManna
Mrs. Frank Inui	Mrs. H. Bryan Hutt	Mrs. Fred Schlecht
Mrs. A. A. Detesco	Mrs. J. G. Guju	Mrs. Donald Dockry
		Mrs. M. W. Neidus

The next Sixth District Councilor meeting will be held in Youngstown next October.

Mrs. W. H. Evans, a National Director of the Woman's Auxiliary to the

American Medical Association, recently returned from Chicago where she attended the National Conference of the Woman's Auxiliary to the American Medical Association for State Presidents and Presidents-elect. She also attended a pre-conference and post-conference Board meeting.

Mrs. Paul E. Ruth, Publicity Chairman

MEETINGS—NOVEMBER, 1959

ACADEMY OF MEDICINE OF CLEVELAND SEMINAR ON RECENT ADVANCES IN DIAGNOSIS AND THERAPY OF MALIGNANT DISEASE, Cleveland, Nov. 18-19. Dr. H. S. Van Ordstrand, 2009 Adelbert Rd., Cleveland 6, Chairman.

AMERICAN ACADEMY FOR CEREBRAL PALSY, Statler Hilton Hotel, Los Angeles, Nov. 30-Dec. 2. Dr. Glidden L. Brooks, Brown University, Providence 12, R. I., Secretary.

AMERICAN COLLEGE OF CHEST PHYSICIANS, Dallas, Texas, Nov. 29-30. Mr. Murray Kornfeld, 112 E. Chestnut St., Chicago 11, Executive Secretary.

AMERICAN MEDICAL WOMEN'S ASSOCIATION, Arlington Hotel, Hot Springs, Ark., Nov 12-15. Mrs. Lillian T. Majally, 1790 Broadway, New York 19, Executive Secretary.

CONFERENCE ON ELECTRICAL TECHNIQUES IN MEDICINE AND BIOLOGY, Sheraton Hotel, Philadelphia, Nov. 10-12. Dr. Herman P. Schwan, Moore School of Electrical Engineering, University of Pennsylvania, Philadelphia, Chairman.

GERONTOLOGICAL SOCIETY, INC., Statler Hotel, Detroit, Nov. 12-14. Mrs. Marjorie Adler, 660 S. Kingshighway Blvd., St. Louis 10, Administrative Secretary.

INTERNATIONAL COLLEGE OF SURGEONS, SECOND WESTERN REGIONAL MEETING, Stardust Hotel, Las Vegas, Nev., Nov. 22-24. Dr. F. M. Turnbull Jr., 1930 Wilshire Blvd., Los Angeles 57, Secretary-Treasurer.

INTER-SOCIETY CYTOLOGY COUNCIL, Statler-Hilton Hotel, Detroit, Nov. 19-21. Dr. Paul A. Younge, 1101 Beacon St., Brookline 46, Mass., Secretary-Treasurer.

NATIONAL SOCIETY FOR CRIPPLED CHILDREN AND ADULTS, Palmer House, Chicago, Nov. 29-Dec. 2. Dr. Dean W. Roberts, 2023 W. Ogden Ave., Chicago 12, Executive Director.

RADIOLOGICAL SOCIETY OF NORTH AMERICA, INC., Palmer House, Chicago, Nov. 15-20. Dr. Donald S. Childs, 713 E. Genesee St., Syracuse 2, N. Y., Secretary-Treasurer.

SAN DIEGO ACADEMY OF GENERAL PRACTICE, Hotel Riviera, Las Vegas, Nev., Nov. 12-14. For information write: Dr. Harold Peterson, 5950 El Cajon Blvd., San Diego 15, Calif.

SOUTHERN MEDICAL ASSOCIATION, Atlanta, Nov. 16-19. Mr. V. O. Foster, 2601 Highland Ave., Birmingham 5, Ala., Executive Secretary-Treasurer.

SOUTHERN THORACIC SURGICAL ASSOCIATION, Edgewater Gulf Hotel, Edgewater Park, Miss., Nov. 19-21. Dr. Hawley H. Seiler, 517 Bayshore Blvd., Tampa 6, Fla., Secretary.

WESTERN SURGICAL ASSOCIATION, The Broadmoor, Colorado Springs, Colo., Nov. 19-21. Dr. John T. Reynolds, 612 N. Michigan Ave., Chicago 11, Secretary.

MEETINGS—DECEMBER, 1959

AMERICAN ACADEMY OF DERMATOLOGY AND SYPHILOLOGY, Palmer House, Chicago, Dec. 5-10. Dr. Robert R. Kierland, First National Bank Bldg., Rochester, Minn., Secretary-Treasurer.

AMERICAN PSYCHOANALYTIC ASSOCIATION, Biltmore Hotel, New York City, Dec. 4-6. Dr. David Beres, 151 Central Park West, New York 23, Secretary.

AMERICAN RHEUMATISM ASSOCIATION, Henry Ford Hospital, Detroit, Michigan, Dec. 11. Gerard W. Speyer, 10 Columbus Circle,New York 19, Executive Secretary.

ASSOCIATION FOR RESEARCH IN NERVOUS AND MENTAL DISEASE, INC. Hotel Roosevelt, New York City, Dec. 11-12. Dr. Rollo J. Masselink, 700 W. 168th St., New York 32, Secretary-Treasurer.

FIRST ANNUAL GRADUATE MEDICAL EDUCATION CONFERENCE-RESIDENCY TRAINING PROGRAM, Univ. of Pennsylvania, Philadelphia, Dec. 3-4. Dr. Alfred S. Frobese, Graduate School of Medicine, U. of Pennsylvania, Philadelphia 3, Chairman.

MEDICAL SOCIETY OF THE UNITED STATES & MEXICO, Valley Ho Hotel, Scottsdale, Ariz., Dec 2-4 (followed by two-day session Desert Inn, Las Vegas, Nev.). Dr. A. H. Tallakson, 2025 N. Central Ave., Phoenix, Ariz., Convention Co-Chairman.

NEW YORK HEART ASSOCIATION, Symposium on Salt and Water Metabolism, Biltmore Hotel, New York City, Dec. 11-12. Dr. Alfred P. Fishman, N. Y. Heart Association, 10 Columbus Circle, New York City, Chairman.

NEW YORK STATE SOCIETY OF ANESTHESIOLOGISTS, INC., Postgraduate Assembly in Anesthesiology, Hotel New York, New York City, Dec. 9-12. Dr. Edwin J. DePolo, 131 W. 11th St., New York 11, Secretary.

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